PROVIDER TYPE PROFILE

PROVIDER TYPE	40	ATTENDANT CARE (**COMPANIES ONLY)**
REIMBURSE-MENT TYPE	02	FEE FOR SERVICE EFFECTIVE 10-01-88

CATEGORIES OF SERVICE			**LICENSE/CERTIFICATION**
MANDATORY	28	ATTENDANT CARE	SIGNED PROVIDER TYPE PROFILE FOR PROVIDER TYPE 40
OPTIONAL	23	HOMEMAKER	
OPTIONAL	26	RESPITE CARE	
OPTIONAL	31	NON EMERGENCY TRANSPORTATION	PROOF OF VEHICLE INSURANCE NOTE: COS 31 UNAVAILABLE FOR 12 MONTHS AFTER APPROVAL.
OPTIONAL	39	PERSONAL CARE	
OPTIONAL	43	SPECIALIZED SERVICES	(EFFECTIVE 10/1/03)
OPTIONAL	47	MENTAL HEALTH SERVICES	(EFFECTIVE 04/01/08)

SPECIAL INSTRUCTIONS: Companies are required to comply with training and recordkeeping standards for Direct Care Workers as outlined in the AHCCCS Medical Policy Manual, Chapter 1200, Section 1240-A. Documentation must be made available to AHCCCS and Contractors upon request.

As part of application process, includes the initial, revalidation and upon a change to your company, the Owner/Provider is required to disclose each "Employee's" full legal name, employment begin date, employment end date (If applicable), Date of Birth, and Social Security Number directly in the AHCCCS Provider Enrollment Portal (APEP).

Any Changes regarding the "Employee" must be reported within 30 days by submitting a modification in APEP.

In addition, the Non-Emergency Transportation category of service will be unavailable for Attendant Care providers for the first year after approval. Additionally, after the first year, this provider type will be permitted to provide a minimum of 70% or more Attendant Care services and can provide no more than 30% Non-Emergency Transportation Care. This requirement only applies to Fee For Service providers and does not apply to registered providers who are contracted with a Managed Care Organization. As the Owner/Provider you are attesting to having a process in place to address any violation of state drug laws by an "Employee" and provide documentation upon request.

By signing below, you are attesting this information will be kept current, on file, and made available upon request to Arizona Health Care Cost Containment System (AHCCCS).

Company Name_____ ID Number_____

Signature_____ Date_____

REVISED 02/15/2022